EXHIBIT 15

*Note: DO not have my Father's contract ~~without the policy number~~!

AIG

Proof of Death
Claimant's Statement

cv 1702151

☑ **American General Life Insurance Company,** P.O. Box 305800, Nashville, TN 37230-5800
☐ **The United States Life Insurance Company in the City of NY**
A member of American International Group, Inc. (AIG)
Overnight: ATTN: Life Claims, #2, American General Center, Nashville TN 37250-0002

To Be Completed By Each Beneficiary *(please print)*				Claim Number
POLICY NUMBER/GROUP NUMBER & CERTIFICATE NUMBER (If multiple policies, please list all) YH0087801				
DECEASED FULL NAME (include middle name) Robert Anthony Chevola		DECEASED SOCIAL SECURITY NUMBER [redacted]		DATE OF BIRTH [redacted]
CAUSE OF DEATH Suicide	DATE OF DEATH 4/16/17	List other hyphenations, nicknames, aliases and/or maiden names used by deceased in the past.		
CLAIMANT'S NAME Zachari Chevola		DATE OF BIRTH [redacted]		SOCIAL SECURITY # OR TIN [redacted]
ADDRESS 13 Macintosh Drive	CITY Middletown	STATE NY	ZIP 10941	RELATIONSHIP TO DECEASED Son
ALTERNATE ADDRESS (Only complete if mailing to separate address from above)	CITY	STATE	ZIP	IN CARE OF
EMAIL ADDRESS [redacted]		TELEPHONE NO. 1845 1803 - 1385		ALT NO. ( )

Have you assigned any of the proceeds of this policy? ☐ Yes ☑ No If yes, who have the proceeds been assigned to? _____ (If copy of assignment is available, please include.)

LIST EACH ASSIGNEE WITH CONTACT NUMBER

IRS/DOL Guidance re: Marriage
For Federal tax law and ERISA purposes, under current IRS and DOL guidance (1) a same-sex marriage that was valid in the state or country it was entered into will be recognized by the IRS and /or DOL, regardless of the married couple's place of domicile; and (2) although a state may recognize domestic partnerships or civil unions, the terms "spouse," "husband and wife," "husband" and "wife" do not include individuals who have entered into a registered domestic partnership, civil union, or other similar formal relationship recognized under state law that is not denominated as a marriage under the laws of that state.

I have read and I understand the important Fraud Disclosure information located on page 8 of this form.

AUTHORIZATION REGARDING _____ ("Insured")
I, the Claimant / Legal Representative of the Insured authorize each insurance company listed above and American General Life Companies LLC (an affiliate services company) (collectively, the "Company") and their authorized representatives including their employees and agents, to provide information to, and, to receive information from, MIB Inc., which operates an information exchange that assists insurance companies with benefit administration, claims, and fraud prevention and detection activities. The authorization will be valid for the duration of the claim or 24 months, whichever is longer. I understand that I may revoke it by giving written notice to the Company, but any action taken by the Company before receipt of such notice will be valid. I acknowledge that I am entitled to obtain a copy of the authorization and a copy will be as valid as the original.

PLEASE SIGN HERE [Zachari Chevola] Signature of Claimant/Legal Representative of the Insured

Zachari Chevola (Printed Name) 6/13/17 (Date)

Certification of Trustee(s) complete this section only if Beneficiary is the Trust

Name of Trust: _____
Tax ID of Trust: _____
The undersigned hereby certify as follows:
1. That they are Trustees under a Trust Agreement dated: _____ Amended: _____
2. That they are the Trustees designated as beneficiary under the above numbered policy(ies);
3. That said Trust Agreement is in full force and effect and that by its terms they are empowered to receive payment of the proceeds of the above policy(ies);
4. That, if applicable, said Trust/Plan is presently fully qualified having met the requirements of Section 401(a) of the Internal Revenue Code.

It is understood and agreed by the undersigned that payment of such proceeds to the Trustees shall discharge the Company from any and all liability therefore and that the Company shall have no responsibility for the carrying out of the Trust Agreement.
The plural as used herein shall include the singular wherever applicable.

Signed this _____ day of _____ 20 _____.

Individual Trustee(s): _____ (Trustee Signature) _____ (Printed Name)

_____ (Signature) _____ (Printed Name) _____ (Signature) _____ (Printed Name)

OR
Corporate Trustee: _____ (Name of Corporate Trustee)

By: _____ (Officer's Signature) _____ (Printed Name) _____ (Title)
(All co-trustees must sign.)

AGLA180A REV0916

—— Payment of Policy Proceeds ——

If your insurance benefit is $50,000 or more, you may elect to have the proceeds paid through a free, interest-bearing account called the Instant Access Account. (This option is not available for residents of Alaska, Arkansas, Connecticut, Indiana, Kansas, Kentucky, Louisiana, Maryland, New Jersey, Rhode Island and New York.)

- This is a draft account whereby you may draw down the insurance proceeds and interest by drafting drafts which are payable through The Bank of New York Mellon.
- A personal draft book will be mailed to you once your claim has been approved. You may access your account by writing a draft for $250.00 or more. If you wish, you can write a single draft for the entire amount, including interest, to close your account. Your drafts are payable through The Bank of New York Mellon. The delivery of your draft book constitutes payment of your full benefit amount.
- There are no monthly service charges, per-draft charges or draft fees. Fees will be charged for the following special services: any draft presented for payment against insufficient funds, any stop payment order, and any draft or statement copies. The charging bank reserves the right to change its fees at any time.
- Should your Instant Access Account balance drop below $10,000, the account will be automatically closed and a draft for the balance mailed to you, with accrued interest on the 10th day of the following month.
- You will receive a Quarterly statement, showing all transactions, interest credited and the applicable rate(s) of interest for the period.
- Your Instant Access Account earns interest at a periodic interest rate determined by the company which is set after monitoring current short term rates and other prevailing rates available in the marketplace.
- The interest rate is subject to periodic review and may be adjusted by the company. There is not a minimum interest rate credited to the account.
- Interest is compounded daily and credited to your account monthly. Interest may be taxable; please consult with your tax advisor regarding taxable interest amounts.
- To obtain the current interest rate for your account, please review your Quarterly statement or call 1-888-562-9158 (M-F) 8 AM - 7 PM Eastern Time.
- Both your principal and any interest you earn are guaranteed by American General Life Insurance Company (American General Life).
- The Instant Access Account is not insured by the Federal Deposit Insurance Corporation (FDIC). Its funds are guaranteed by the State Guaranty Associations. Please contact the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com) to learn more about coverage of your account.
- Account balances are the liability of American General Life, and American General Life reserves the right to reduce account balances for any payment made in error.
- Settlement options under any policy for which benefits are paid under a Instant Access Account are preserved until the entire Instant Access Account is withdrawn or the balance drops below $10,000.00.
- If an initial life insurance benefit is less than $50,000, American General Life will send you a check for the total benefit amount.
- Any value remaining in your Instant Access Account may be transferred to the appropriate state authority as unclaimed property if no activity occurs in the account within the time period specified by applicable state law.

If you have questions regarding the Instant Access Account, please call 1-888-562-9158 (M-F) 8 AM - 7 PM Eastern Time or write to Instant Access Account, P.O. Box 534025, Pittsburgh, PA 15253-4025.

Select one of the following choices:

- ☐ Please pay the insurance proceeds through the Instant Access Account **(Not available if you are a resident of Alaska, Arkansas, Connecticut, Indiana, Kansas, Kentucky, Louisiana, Maryland, New Jersey, Rhode Island and New York).**
- ☑ Please pay the insurance proceeds by Lump Sum - Settlement Check.
- ☐ Please pay the insurance proceeds by means of a Settlement Option permitted by the Policy (please refer to settlement options in the policy and indicate your preference).

_____

_____

If you do not select one of the options above for payment, any proceeds payable will be paid by company check.
Note: The signature on this Claimant's Statement will be used as your signature card for the Instant Access Account, if selected.

Zachari Chevalier
Signature

Date: 6/13/17

WITHHOLDING ELECTION:

Please read the Notice of Federal Withholding Election on the bottom of this page prior to completing this section.

I hereby accept full and sole responsibility for payment of federal and state taxes which may be associated with this claim.

Unless you check Option "A" below, "I DO NOT want to have Federal income tax withheld," we are required to withhold at least 10% of the taxable amount.

_✓_ A. I DO NOT want to have Federal income tax withheld.

_____ B. I DO want to have _____ % Federal income tax withheld (10% minimum).*

Even if you elect not to have Federal income tax withheld, you are liable for payment of Federal income tax on the taxable portion of the distribution. You also may be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate.

* Note: If you elect federal withholding, state income tax withholding is mandatory in the following states: CA, DE, GA, IA, KS, ME, MA, MS, NC, OK, OR, VT, and VA. Unless these states' laws require otherwise, or you request a different withholding amount by providing American General Life Insurance Company the applicable state form, we will withhold state income tax based on federal guidelines. In other states with a state income tax, state income tax withholding is voluntary. However, you may be liable for payment of state income tax on the taxable portion of your distribution.

TAXPAYER IDENTIFICATION NUMBER:

This section must be completed and signed by the Claimant / Beneficiary identified on Page 1 of this form. Failure to do so may delay your request.

Please enter your taxpayer identification number in the appropriate box. For individuals and sole proprietors, this is your social security number. For other entities, it is your employer identification number. If you do not have a number, see IRS Publication 505.

Social Security Number [redacted] OR Taxpayer Identification Number | | | - | | | | | | | |

IRS Certification: Under penalties of perjury, I certify that: 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding (enter exempt payee code*, if applicable: _____), OR (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person*, and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct (enter exemption from FATCA reporting code, if applicable: _____). **Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For contributions to an individual retirement arrangement (IRA) and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. *See General Instructions provided on the IRS Form W-9 available from IRS.gov. ** If you can complete a Form W-9 and you are a U.S. citizen or U.S. resident alien, FATCA reporting may not apply to you. Please consult your own tax advisors.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Zachary Chenda

Claimant / Beneficiary Signature

Date 6/13/17

NOTICE OF FEDERAL WITHHOLDING ELECTION

The distributions you receive from American General Life Insurance Company are subject to Federal income tax withholding unless you elect not to have withholding apply. Withholding will only apply to the portion of your distribution that is included in your income subject to Federal income tax. Thus, for example, there will be no withholding on the return of your nondeductible contributions to the contract.

You may elect not to have withholding apply to your distribution by marking Option A under the Withholding Election section on Page 2 of this form. If you do not mark Option A, Federal income tax will be withheld from the taxable portion of your distribution.

If you elect not to have withholding apply to your distribution or if you do not have enough Federal income tax withheld from your distribution, you may be responsible for payment of estimated tax. You may incur penalties under the estimated tax rules if your withholding and estimated tax payments are not sufficient.

If You Are Claiming Any Accidental Death Benefits

Please complete this section: (Include copies of available newspaper clippings and/or police report giving circumstances)
Type of Accident:

_____

Date: _____ Location: _____

Details: _____

_____

_____

_____

Investigating Officer/Agency:

Name: _____

Address: _____

Phone Number: _____

If Manner Of Death Was Homicide

Motive? _____ Arrest Made? ☐ Yes ☐ No

Suspects? (Give names) _____

Trial pending? ☐ Yes ☐ No

Witnesses? (Give names, addresses, phone numbers)

_____

Investigating Officer/Agency:

Name: _____

Address: _____

Phone Number: _____

If Policy Has Been In Force For Less Than Two Years, please complete this section:

Please provide a statement of medical history for the deceased. Include Name, Address, Phone Number and year of treatment for all Doctors, Hospitals, and Clinics that had ever treated the deceased. Also, include the name of the Pharmacy and Group Insurance Carrier. If additional space is needed please include a separate page if necessary.

The Company Will Order These Records.

Health or Member ID No.: _____

Carrier: _____

Address: _____

_____

Phone Number: _____

Insured: _____

Pharmacy: _____

Address: _____

_____

Phone Number: _____

Doctor/Hospital: _____

Address: _____

_____

_____

Phone Number: _____

Year of Treatment: _____

Doctor/Hospital: _____

Address: _____

_____

_____

Phone Number: _____

Year of Treatment: _____

Doctor/Hospital: _____

Address: _____

_____

_____

Phone Number: _____

Year of Treatment: _____

Year of Treatment: _____

Doctor/Hospital: _____

Address: _____

_____

_____

Phone Number: _____

Year of Treatment: _____

Year of Treatment: _____

AIG

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information

A member of American International Group, Inc. (AIG)

Robert Anthony Chevola [redacted]

Name of Insured (Please Print) **Date of Birth**

I, the Insured above or the Personal Representative acting on behalf of the Insured, hereby authorize all of the people and organizations listed below to give American General Life Insurance Company ("AGL"), The United States Life Insurance Company in the City of New York ("US Life"), and any affiliated services company (AGL, US Life and affiliated services companies collectively "the Companies"), and their authorized representatives, including agents and insurance support organizations (collectively, the "Recipient"), the following information:

- any and all information relating to the Insured's health (except psychotherapy notes) and the Insured's insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; drug prescriptions, and communicable diseases including HIV or AIDS; and
- Information about me, including my name, address, telephone number, gender and date of birth.

I hereby authorize each of the following entities to provide the information outlined above to:

- any physician, nurse or medical practitioner or practitioner group;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any of the Companies (as defined above) which may have provided the Insured with life, accident, health, and/or disability insurance coverage, or to which the Insured may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- the Insured's employer, group policy holder, or benefit plan administrator;
- the Medical Information Bureau (MIB); and
- _____

I understand that the information obtained will be used by the Recipient to:

- determine the Insured's eligibility for benefits under and/or the contestability of an insurance policy; and
- detect fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the Companies are subject to certain federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I understand that the Recipients requesting access to the (electronic or paper) medical records are acting as a patient authorized representative and will attempt to access the medical records in an efficient manner, including electronic interchange through a Health Exchange or directly through the Providers' electronic health record system.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Insurance Company, Attn: Life Claims Department - 460, P.O. Box 305800, Nashville TN, 37230-5800. I understand that my revocation of this authorization will not affect uses and disclosure of the Insured's health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under the Insured's insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the information necessary to consider a claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under the Insured's insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive, upon request, a copy of this authorization.

Zachari Chevola
Printed Name of Insured or Personal Representative

Policy Number/ Control Number

x Zachari Chevola
Signature of Insured or Insured's Personal Representative

6/13/17
Date

Printed Name of Witness

Relationship

x
Witness Signature (if required)

Date

Description of Authority of Personal Representative

Doctors, Health Facilities, Rehabilitation Centers for Robert A. Chevola

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

He was also in a [redacted]

for about [redacted]

I am enclosing a certified death certificate for my Father. I am the sole beneficiary of his will. If you need a copy of his Will, please let me Know.

Thank you.

Zachari Chevola

13 Macintosh Drive
Middletown, NY 10941 845-803-1385

STATE OF NORTH CAROLINA

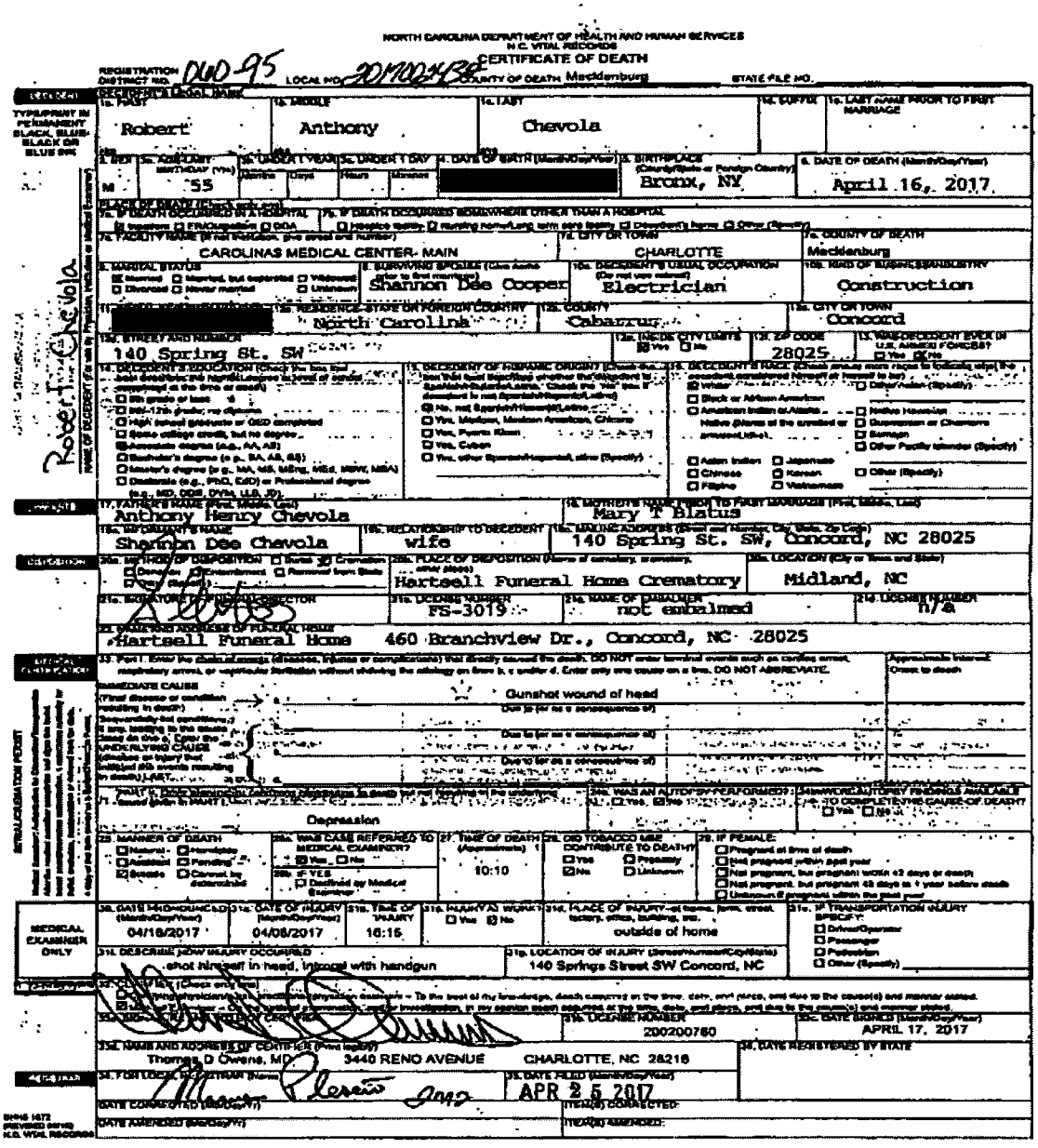
CERTIFICATION OF VITAL RECORD

MECKLENBURG COUNTY

REGISTER OF DEEDS - HEALTH DEPARTMENT

CHARLOTTE, NORTH CAROLINA

CERTIFICATE OF DEATH



NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
N.C. VITAL RECORDS
CERTIFICATE OF DEATH

REGISTRATION DHD TRACT NO. 060-95 LOCAL NO. 20170034[illegible] COUNTY OF DEATH Mecklenburg STATE FILE NO.

DECEDENT'S LEGAL NAME
1a. FIRST: Robert | 1b. MIDDLE: Anthony | 1c. LAST: Chevola | 1d. SUFFIX | 1e. LAST NAME PRIOR TO FIRST MARRIAGE

2. SEX: M | 3a. AGE-LAST BIRTHDAY (Yrs): 55 | 3b. UNDER 1 YEAR (Months/Days/Hours/Minutes) | 3c. UNDER 1 DAY (Hours/Minutes) | 4. DATE OF BIRTH (Month/Day/Year): [redacted] | 5. BIRTHPLACE (City/State or Foreign Country): Bronx, NY | 6. DATE OF DEATH (Month/Day/Year): April 16, 2017

PLACE OF DEATH (Check only one)
7a. IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA | 7b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Residence (home) ☐ Nursing home/facility (not part of hospital) ☐ Decedent's home ☐ Other (Specify)
7c. FACILITY NAME (If not inpatient, give street and number): CAROLINAS MEDICAL CENTER- MAIN | 7d. CITY OR TOWN: CHARLOTTE | 7e. COUNTY OF DEATH: Mecklenburg

8. MARITAL STATUS: ☒ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never married ☐ Unknown | 9. SURVIVING SPOUSE (Give name first and maiden name if applicable): Shannon Dee Cooper | 10a. DECEDENT'S USUAL OCCUPATION (Do not use retired): Electrician | 10b. KIND OF BUSINESS/INDUSTRY: Construction

11. RESIDENCE-STATE OR FOREIGN COUNTRY: [redacted] North Carolina | 12. COUNTY: Cabarrus | 13. CITY OR TOWN: Concord

14. STREET AND NUMBER: 140 Spring St. SW | 15. INSIDE CITY LIMITS: ☒ Yes ☐ No | 16. ZIP CODE: 28025 | 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☒ No

18. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death): ☐ 8th grade or less ☐ 9th-12th grade; no diploma ☐ High school graduate or GED completed ☐ Some college credit, but no degree ☐ Associate degree (e.g., AA, AS) ☐ Bachelor's degree (e.g., BA, AB, BS) ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

19. DECEDENT OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is of Hispanic origin or not. If decedent is of Hispanic origin, check the box that best describes the decedent's Hispanic origin.): ☒ No, not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino (Specify)

20. DECEDENT'S RACE (Check one or more races to indicate what he or she considered himself or herself to be): ☒ White ☐ Black or African American ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander (Specify) ☐ Asian Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ Other (Specify) ☐ Filipino ☐ Vietnamese

DECEDENT'S NAME: Robert Anthony Chevola

21. FATHER'S NAME (First, Middle, Last): Anthony Henry Chevola | 22. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): Mary T Blatus

23a. INFORMANT'S NAME: Sharnon Dee Chevola | 23b. RELATIONSHIP TO DECEDENT: wife | 23c. MAILING ADDRESS (Street and Number, City, State, Zip Code): 140 Spring St. SW, Concord, NC 28025

DISPOSITION
24a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify) | 24b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Hartsell Funeral Home Crematory | 24c. LOCATION (City or Town and State): Midland, NC

25a. SIGNATURE OF FUNERAL DIRECTOR | 25b. LICENSE NUMBER: FS-3019 | 25c. NAME OF EMBALMER: not embalmed | 25d. LICENSE NUMBER: n/a

26. FUNERAL FACILITY NAME AND ADDRESS: Hartsell Funeral Home 460 Branchview Dr., Concord, NC 28025

CERTIFICATION FOR FOUR

27. Part I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology on lines a, b, or d. Enter only one cause on a line. DO NOT ABBREVIATE. | Approximate Interval: Onset to death

IMMEDIATE CAUSE (Final disease or condition resulting in death): Gunshot wound of head | Due to (or as a consequence of):
SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO THE IMMEDIATE CAUSE. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST: | Due to (or as a consequence of): | Due to (or as a consequence of):

Part II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.: Depression

28a. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No | 28b. WAS AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

29. MANNER OF DEATH: ☐ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined | 30a. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ Yes ☐ No | 30b. IF YES: ☐ Declined by Medical Examiner | 31. TIME OF DEATH (Approximate): 10:10 | 32. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☒ No ☐ Unknown | 33. IF FEMALE: ☐ Pregnant at time of death ☐ Not pregnant within past year ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year

MEDICAL EXAMINER ONLY

34. DATE OF INJURY (Month/Day/Year): 04/16/2017 | 35. TIME OF INJURY: 16:15 | 36. INJURY AT WORK? ☐ Yes ☒ No | 37. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): outside of home | 38. IF TRANSPORTATION INJURY SPECIFY: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

39. DESCRIBE HOW INJURY OCCURRED: shot himself in head, injured with handgun | 40. LOCATION OF INJURY (Street/Number/City/State): 140 Springs Street SW Concord, NC

41. I CERTIFY (Check only one): ☐ That to the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. ☐ That to the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.

42a. SIGNATURE OF CERTIFIER | 42b. LICENSE NUMBER: 200200760 | 42c. DATE SIGNED (Month/Day/Year): APRIL 17, 2017

42d. NAME AND ADDRESS OF CERTIFIER (Print legibly): Thomas D Owens, MD 3440 RENO AVENUE CHARLOTTE, NC 28216 | 42e. DATE REGISTERED BY STATE

43. FOR LOCAL REGISTRAR ONLY: Marcus Plescia MD | 43b. DATE FILED (Month/Day/Year): APR 25 2017

DATE CORRECTED (Month/Day/Yr): | ITEM(S) CORRECTED: | DATE AMENDED (Month/Day/Yr): | ITEM(S) AMENDED:

DHHS 1672 (REVISED 04/08) N.C. VITAL RECORDS

THIS IS TO CERTIFY THIS IS A TRUE AND CORRECT REPRODUCTION OF THE OFFICIAL RECORD FILED IN MECKLENBURG COUNTY.

V 962087

WITNESS MY HAND AND OFFICIAL SEAL THIS DAY May 9, 2017

RAISED SEAL

Marcus Plescia, MD,MPH
Health Director & Registrar

Fredrick Smith
Register of Deeds

By: _____
Assistant/Deputy Register of Deeds

THIS DOCUMENT CONTAINS AN ORIGINAL WATERMARK
ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE